NORTH CAROLINA MEDICAID

Request for Medical Review for Synagis Outside of Criteria

Patient Name: _____ Patient DOB: _____/_____/_____

Patient Medicaid ID**#:** _____

Drug Name & Strength: _____

Dosage: _____

Patient's Estimated Gestational Age (in weeks): _____

Prescriber Name (please print): _____

Practice Name: _____

Prescriber Address: _____

Prescriber DEA# _____ Medicaid Provider # _____

Office Contact: _____

Prescriber phone # _____ Prescriber fax# _____

Provide justification below of the medical necessity of the above-named medication for this patient:

*Signature of Prescriber: _____ Date: _____

***Prescriber signature mandatory.**

Please Fax to DMA at 919-715-1255

FOR DIVISION OF MEDICAL ASSISTANCE (DMA) USE ONLY

Date: _____ Notified: _____

Approved: _____ Denied: _____

Reason: _____